Personal History

Name (last, first, MI) Soc. Sec. Birthdate

_____ - - ___/___/___

Home address (street, city, state, zip code)__ Phone _____

_____ Cell _____

_____ Email_____

Referred by: _____
Are you currently under the care of a physician? Y or N
If yes please list condition and medications. _____

List any surgeries or operations: _____

Nutritional supplements, vitamins, etc. _____

Medication allergies: _____

My health is: excellent good fair poor (circle one)

My physical fitness is: excellent good fair poor (circle one)

Exercise habits: never occasional routinely ____hrs. ____x/week

Patient Signature: _____

Print: _____

Date: _____

READINESS ASSESSMENT/Questionnaire

1. What is the most important reason you want to lose weight?

2. Are you ready to commit to change? Yes or No Signature: _____

3. Do you have support at home to make this change? Yes or No

4. Do you use food in response to stressful situations? Yes or No

5. What are some of your favorite foods?

6. Do you eat late at night? Yes or No

7. Do you crave foods? Yes or No

8. Have you ever used appetite suppressants or supplements? Yes or No
   If yes, list names and any adverse reaction.

9. Have you participated in any other weight management program? Yes or No

10. Did you adhere to or complete the program? Yes or No
    If no, explain why.

11. How much weight do you expect to lose?

12. How long do you expect it will take to lose it?
    (hCG is 23 or 40 days and can be done multiple times to lose the desired weight)

13. Are you currently going through any major life stressors? Yes or No
    Please explain.

14. Are you able to come in for weekly weigh in visits?